

Clayton, Sidney

224797

INFIRMARY NURSING PROGRESS NOTES

Date/Time	
4/11/87 8:11	<p>9 to low Buckle</p> <p>9 Curran Pic to lower Buckle.</p> <p>DTM - the</p> <p>no waterfalls -</p> <p>that m</p> <p>Excl</p> <p>A/D Buckle Re</p> <p>will give Advise R</p>

INMATE NAME (LAST, FIRST, MIDDLE)	DOC#	DOB	R/S	FAC
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Date/Time	Inmate's Name:	D.O.B.:
3-30-06	Clayton Seidman	3/23/76
	Wt 189, 198'8", B/P 128/80 R20, O2 98%, P 76	
	40 'Sinuses' ① 750, ② 450 ③ 500	

① Yellow Sputum
 Not Severe
 Tender Lungs Sites
 Frontal Abs -
 Other Exam Normal
 Lung Abs. Rhonchi
 Mild Exp. Wheeze +
 RR - NL -
 CV - NRR
 Abd. Soft NT

(A) APTA -
 Non Compliant -
 no evidence of Bacteraemia - clinically

(B) Cont. Humid -
 Round 1 lb 3m

(C) Complx

4/12/06 ① Hx for Keyloch

② apparent poor vision

App will fix Keyloch until see
 by Eye doctor



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PROGRESS NOTES

Date/Time	Inmate's Name:	D.O.B.:
3/17/06 0803	Clayton Sidney #22497	03 13 176
	Referral from MS Floyd R/T wheezing Wt 192 lbs O ₂ Sat 98% P 166 BP 140/60 T 98.6 R-20 Q SOB - COP	
(P)	Bil Rhonchi — Has previous Hx no wheezing mild Ast — wheezing Lung CTA CV-NR	
(A)	mild - Exacerbation of the asthma	
(P)	jet neb humid — predm <u>one</u>	
(E)	Report Hx — and SOB h	
3-24-06	Wt 192, P 78, O ₂ sat 96%, T 98.8, R 18, BP 110/70 Peak flow ① 550, ② 450 ③ 300	
(O)	BS Normal — Bil. Rhonchi — Now - Compl - ant -	
(A)	Resolving asthma Exacerbation mild,	
(P)	Cont Rx	
(E)	Comply, h	

Date/Time	Inmate's Name:	254797	D.O.B.:	3123176
3.15.06	Wt. 191	P65	T98	B/p 122/16 R 122/16 025at 98%
	CRNP request to see 29Bm for flu? Saw			
	DR 1-3-06 clo back pain and request for BB - denied			
	Based on physical finding by MD reports on BB today			
	S hope to fear it will be removed by Doc Xray 12/6/05			
	result will be normal impression by radiologist			
	MD USS indicates S D. difficulty remove			
	Shoe S difficulty pulls shirt up over shoulder			
	S any difficulty noted today			
	Numb on test			
	MS - Spinal process w/ L @ masses 21+ to			
	Pulp @ bruises @ cuts From			
	Ext @ ECC From muscle strength 44 B.I.P.			
	reflexes 2+ B.I. PP 2+ DP 2+ D.I. SLR @ ROL			
A	normal Physical exam			
P	Safety to exercise bunk Bed at knee to			
	Pick up wt 11 Exercises as tolerated cont to do			
	Back exercise as DR recommended			
	instructed to use ladder bars at end of bunk			
	for climbing and avoid jumping down from			
	Bunk RR Prow			

J. L. Lewis



PROGRESS NOTES

Date/Time	Inmate's Name:	224797	D.O.B.:
1-3-06	WT 192 T 56" P 80 R 20 B/p 150/100		3123176

0) Able to Remove shoes
 easily undressed —
 shoulders - ROM NL
 LS spine —

Flex - full ROM

NT —

NO deformity

Ext R & L

NO motor deficit

(A) Hacking

~~No need for~~ BB - denied

(P) Back Exercises

Monitor BP

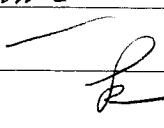
(E) Comply

[Signature]



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PROGRESS NOTES

Date/Time	Inmate's Name:	D.O.B.:
2.7.05	Clayton, Sidney 224797	3 123 176
	188 wt. P103 T96.8 B1/p 11/10 R18	
	90 back pain / Shaving Profile / weight loss	
	C) Exaggerating Symptoms	
	Tender mildly	
	Thoracic area —	
	NT. LS-Spine area —	
	NO NEW Δ	
	NO Swelling	
	ROM Normal	
	EXCEPT L4/L5 back	
	Other MS Exam NL	
	(A) back sprain	
	no any #	
	P) XR —	
	pending	
	(S) Compliance	
		

Date/Time

Inmate's Name:

D.O.B.:

/ /

12-20-05

WT 192 P 60 T 96.8 B/p 132/70 R 20
 C/o back pain

L5 spine

ROM NL

NT

No kneeling

This in meth is
 extremely manipulative,
 maligering - and
 seeking pretext to
 create trouble to himself
 and others

(A) Normal LS -

(P) Back Exercises - no need for N/A - h

(E) Regular Exercises - R - Reviewed

NL -

Addendum -

clinical
 no evidence of any ch pain any when
 a MHA - Counseling may benefit

h

12



PRISON
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PROGRESS NOTES

Date/Time	Inmate's Name:	D.O.B.:
12-05-05	Clayton Sidney	3 123176
	wt. 186. P 72 T 99.8 B/p 122/80 R20	
	10 Nausea/Vomiting dizziness Hepatitis Fainting Spell	
	0) NO vomiting — to-day one yesterday	
	2) Tender over Lenses — Cong. Nasal Mucosa — abd. Soft NT no palpable masses	
	(A) Sinner to Allergic — e nausea dizziness recklessness — in leg	
	B) Penicillin Humbly	
	(E) Reg. Wright h	



PRISON
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PROGRESS NOTES

Date/Time	Inmate's Name:	D.O.B.:
10/24/05-	Clayton, Sidney	/ /
	Wt. 192# P68 T97.4 B/p 118/80 R20	
	C/o sinus	
	<p>0) Cong Nasal Mucosa — Tender over frontal sinuses Turbinates mildly hypertrophied</p>	
	(A) Chr Allergic Rhinitis	
	(P) ETH	
	(E) Empty	
11/30/05	Wt. 189 P59 T98.8 B/p 118/80 R18	
	C/o S' He wants to be tested for Hepatitis B Vac	
	<p>0) Never Blood Transfusion / Tattoo & drug abuse & Cocaine / Meds —</p>	
	P/E.	
	Normal — & Liver Enlargement	
	NT —	
	(A) assured. NO med unlikely to have hepatitis	
	(P) med Medically not necessary to do LAB	
	(E) NO R's or factors or clinical correlation	

Date/Time Inmate's Name: ~~Murray, Joseph~~ #224797 DOB: 1 1
 9/14/05 Wt. 189# B/p 120/82 P76 R18 T98.4
 C/D sinus congestion Im Clayton Sedney 3/23/
 29 Bm pr cp A above x 3 yrs H/S # 224797
 c reported watery eyes, sneezing & runny nose
 NAD US A40X3 N/A
 HEENT Jm's intact nose throat clear c
 shiny clear exudate & throat noted 0 redness
 0 lymph 0 sinus tend to palp 0 appetite
 Lung clear
 A acute allergic sinusitis Non smoker
 P/ Sudafed Tpo B10X 1 week
 1/E Cough tabs i po x 10 days
 ctm Tpo B10X 1 week
 Dorycline 100mg i po B10X 1 week
 T Fluid Compliance to meds
 Rte low Hay fever

10/3/05-9:25am Wt. 188# P56 T96.8 B/p 138/80 R20
 C/D Sinus

0) No Issues —

(A) mild allergy

P) Const EB

(E) Reg. Exercise

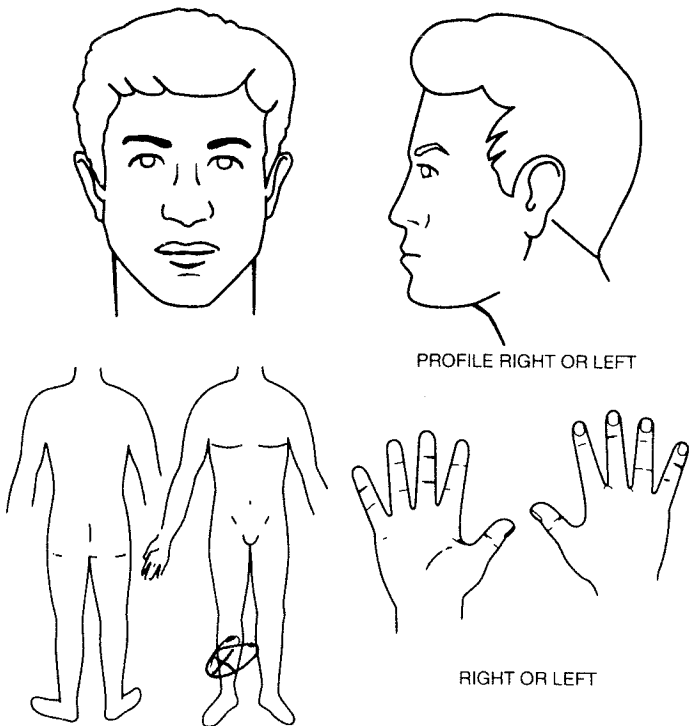


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PROGRESS NOTES

Date/Time	Inmate's Name:	D.O.B.:
	Clayton, Sidney	/ /
12/16/03	Sat 40 BM wants to renew shaving profile	
	ONAD noted:	
	face clear - few old scars & mild discoloration.	
	of papules/pustules	
	A Chronic facial folliculitis	
	P Renew profile x 6 mo	
6-18-04	WT 217 BP 140/90 P 69 R 20 T 98.8	CCB/KyCw
11-20	S - "Renew shave profile" - McNezfield	
	Few follicles - sealed	
	(A) Sp - mild facial folliculitis	
	(P) Sp - 6 mo	
	Shing	
12/17/04	WT 206 3/4 lbs T 97.8 P 68 Pulse 98 BP 140/100	
	Renewal of shaving profile	
	(A) mild facial folliculitis	
	(A) facial folliculitis	
	(P) Sp	
	(C) Sp Experience	

EMERGENCY

ADMISSION DATE 7 / 13 / 06		TIME 8 AM	ORIGINATING FACILITY BCCF		<input type="checkbox"/> SICK CALL <input type="checkbox"/> EMERGENCY <input type="checkbox"/> OUTPATIENT	
ALLERGIES N/A			CONDITION ON ADMISSION <input type="checkbox"/> GOOD <input checked="" type="checkbox"/> FAIR <input type="checkbox"/> POOR <input type="checkbox"/> SHOCK <input type="checkbox"/> HEMORRHAGE <input type="checkbox"/> COMA			
VITAL SIGNS: TEMP 98.6		ORAL RECTAL	RESP 18	PULSE 98	B/P 122/9	RECHECK IF SYSTOLIC <100> 50
NATURE OF INJURY OR ILLNESS S. Soft ball hit my leg O. 30 y/o Blm to HCHS ambulatory ad leg no wet swelling to leg Shen remain in fact Shen wld to touch my leg A. Alteration in comfort P. Released to Doc			ABRASION /// CONTUSION # BURN xx FRACTURE Z LACERATION / SUTURES			
PHYSICAL EXAMINATION						
DIAGNOSIS			ORDERS / MEDICATIONS / IV FLUIDS Motrin 800 mg q 6h for pain			
INSTRUCTIONS TO PATIENT I if condition worsen return to see me			CONDITION ON DISCHARGE <input checked="" type="checkbox"/> SATISFACTORY <input type="checkbox"/> POOR <input type="checkbox"/> FAIR <input type="checkbox"/> CRITICAL			
DISCHARGE DATE 7 / 13 / 06		TIME 8:03 AM	RELEASE / TRANSFERRED TO DOC		CONSULTATION	
NURSE'S SIGNATURE J. DuBois		DATE 7/13/06	PHYSICIAN'S SIGNATURE [Signature]		DATE	
INMATE NAME (LAST, FIRST, MIDDLE) Clayton, Sidney			DOC# 224797	DOB 3/13/76	R/S Blm	FAC BCCF

DEPARTMENT OF CORRECTIONS
TRANSFER & RECEIVING SCREENING FORM

RECEIVED: Inmate/Health Record Institution: <u>BCCF</u> Date: <u>4/24/06</u> Time: <u>11:00</u> AM/PM RECEIVED FROM: Institution/Work Release Center/Free-World Hospital	RELEASED: Inmate/Health Record Institution: <u>VCF</u> Date: <u>4-10-06</u> Time: <u>11:00</u> AM/PM RELEASE FROM: <input type="checkbox"/> Infirmary <input checked="" type="checkbox"/> Segregation <input type="checkbox"/> Population <input type="checkbox"/> Mental Health <input type="checkbox"/> Other _____ RELEASE TO: <input type="checkbox"/> DOC <input type="checkbox"/> Infirmary <input type="checkbox"/> Mental Health <input type="checkbox"/> _____ Institution/Work Release Center/Free-World Hospital	ALLERGIES: <u>NKA</u> PHYSICAL EXAMINATION Date of last exam: <u>3-7-06</u> Chest X-Ray Date: _____ Result: _____ PPD Reading <u>Ø</u> Classification: _____ Limitations: _____
RECEIVING MEDICAL STATUS <input checked="" type="checkbox"/> Population <input type="checkbox"/> Infirmary <input type="checkbox"/> Isolation		

LAB RESULTS - - LAST REPORT	YES	NO
CBC _____ Date _____ Normal <input type="checkbox"/> Abnormal <input type="checkbox"/>	Wears Glasses/Contacts <input type="checkbox"/>	<input checked="" type="checkbox"/>
Urinalysis _____	Dental Prosthesis <input type="checkbox"/>	<input checked="" type="checkbox"/>
	Hearing Aide <input type="checkbox"/>	<input checked="" type="checkbox"/>
	Other Prosthesis <input type="checkbox"/>	<input checked="" type="checkbox"/>
		<input checked="" type="checkbox"/> Receiving Nurse

CURRENT OR CHRONIC MEDICAL/DENTAL/MENTAL HEALTH PROBLEMS OR COMPLAINTS

asthma (mild)

CURRENT MEDICATION - DOSAGE AND FREQUENCY

Proventil 4mg po BID
x 14 days
Humicid 600mg po BID
CTM 8mg po qd x 14

MEDICATIONS ☐ Sent w / inmate ☐ Not sent w / inmate
X-RAY FILM ☐ Sent w / inmate ☐ Not sent w / inmate
HEALTH RECORD ☐ Sent w / inmate ☐ Not sent w / inmate
Released to: Walden

Date: _____ Time: _____ AM/PM

MEDICATIONS ☐ Received ☐ Not Received
X-RAY FILM ☐ Received ☐ Not Received
HEALTH RECORD ☐ Received ☐ Not Received
CHART REVIEWED ☐ YES ☐ NO

Received by: Walden
Signature of Receiving Nurse

Date: _____ Time: _____ AM/PM

SCHEDULE FOR CHRONIC CARE CLINIC

DATE: _____ LAST CLINIC: _____

FOLLOW-UP CARE NEEDED	Date	Time	With Whom - - Location (Sending Nurse)	Date/Appt Made w/Whom (Rec. Nurse)
<input type="checkbox"/> Medical <input type="checkbox"/> Dental	_____	_____	_____	_____
<input type="checkbox"/> Mental Health	_____	_____	_____	_____

NURSING ASSESSMENT (SENDING NURSE)
(Noted from health record documentation)

	Yes	No
HISTORY		
Drug Use	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Mental Illness	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Suicide Attempt	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Chronic Care	<input checked="" type="checkbox"/>	<input type="checkbox"/>

STATUS		
Special Diet	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Appearance	<input checked="" type="checkbox"/>	<input type="checkbox"/>

OTHER PERTINENT NURSING ASSESSMENT

NURSING ASSESSMENT (RECEIVING NURSE)
(Noted from inmate assessment)

	Yes	No
SKIN		
Open Sores	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Lice	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Edema	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Warm & Dry	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Cool & Moist	<input checked="" type="checkbox"/>	<input type="checkbox"/>

CONDITION		
Alert	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Oriented	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Uncooperative	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Depressed	<input type="checkbox"/>	<input checked="" type="checkbox"/>

INTAKE

Sick Call Procedures Explained yes
Height 5'6"
Weight 194
Blood Pressure 110/76
Temperature 98.6
Pulse Resp 78/18
Other _____

Signature of Nurse Completing Assessment (Sending Nurse)

Date

Signature of Intake Screening Nurse (Receiving Nurse)

Date

INMATE NAME (LAST, FIRST, MIDDLE) <u>Clayton Sidney</u>	DOC# <u>224797</u>	DOB <u>3-23-76</u>	Race/Sex <u>B/m</u>	FAC <u>VCF</u>
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IDENTIFICATION OF SPECIAL NEEDS

NAME (PLEASE PRINT) Platten, Susan

LAST

FIRST

MI

DATE OF BIRTH 2-23-76

SS# 224197

Housing Recommendations:

General Population General Population

Medical Observation Unit Medical Observation Unit

Lower Level/Lower Bunk KCP

Suicide Precautions 10-11-05 - 1-11-06

Special Watch (15 Minute Checks) 10-11-05 - 1-11-06

Isolation

Initiate Universal Precautions

Individual found to be:

Frail/Elderly

Physically Handicapped

Developmentally Disabled

Drug/Alcohol Withdrawal

Special Mental Health Needs

Expressed Suicidal Ideation

History of Seizures

Other

Specify

Nurse [Signature]

Date 11-21-05



**PRISON HEALTH SERVICES, INC.
SICK CALL REQUEST**

Print Name: Sidney Clayton-Bey Date of Request: 4/24/06
ID # 224797 Date of Birth: 3/23/76 Location: 26-12
Nature of problem or request: My Kop Sinus medicine has ran out. I can't
sleep right because of my aggravated Sinus. (Note) This is
a follow up on treatment.

Sidney Clayton-Bey
Signature

DO NOT WRITE BELOW THIS LINE

Date: ____/____/____
Time: ____ AM PM
Allergies: _____

RECEIVED
Date: _____
Time: _____
Receiving Nurse Initials _____

(S)ubjective:

(O)bjective

(A)ssessment:

(P)lan:

Refer to: MD/PA Mental Health Dental Daily Treatment Return to Clinic PRN
CIRCLE ONE

Check One: ROUTINE () EMERGENCY ()

If Emergency was PHS supervisor notified: Yes () No ()

Was MD/PA on call notified: Yes () No ()

SIGNATURE AND TITLE

WHITE: INMATES MEDICAL FILE

YELLOW: INMATE RETAINS COPY AFTER NURSE INITIALS RECEIPT

Nursing Evaluation Tool:

General Sick Call

Facility: Alabama Department of Corrections

Patient Name: Clayton Sidney

Inmate Number: 224797^{1st}Date of Birth: 3/23/76
MM DD YYDate of Report: / /
MM DD YY

Time Seen: AM/PM Circle One

Subjective: Chief Complaint(s): Back pain (Chronic) Problem with feet need
Onset: something fell. Support. Denies problemBrief History: was taking CTM that was helping also
(Continue on back if necessary) I would like extra mattressObjective: Vital Signs: (As Indicated) T: 97.8 P: 80 RR: 18 BP: 120/80 wt 198
□ Check here if additional notes on backExamination Findings:
(Continue on back if necessary)

Assessment: (Referral Status)

Preliminary Determination(s):

□ Check here if additional notes on back

☒ Referral NOT REQUIRED☐ Referral REQUIRED due to the following: (Check all that apply)☐ Recurrent Complaint (More than 2 visits for the same complaint)☐ Other:

Comment: You should contact a physician and/or a nursing supervisor if you have any concerns about the status of the patient or are unsure of the appropriate care to be given.

Plan: Check All That Apply:

☐ Instructions to return if condition worsens.☐ Education: The patient demonstrates an understanding of the nature of their medical condition and instructions regarding what they should do as well as appropriate follow-up. ☐ YES ☐ NO (if NO then schedule patient for appropriate follow-up visits)☐ Other:OTC Medications given (Describe) ☒ NO ☐ YES (if Yes List):Referral: ☐ NO ☒ YES (if Yes, Whom/Where): Dr. SedgDate for referral: 4/4/06
MM DD YYReferral Type: ☐ Routine ☐ Urgent ☐ Emergent (if emergent who was contacted?):L. Anderson
Nurses Signature

Name:

Printed



**PRISON HEALTH SERVICES, INC.
SICK CALL REQUEST**

Print Name: Sidney Clayton Date of Request: 4/12/06
ID # 224797 Date of Birth: 3/23/76 Location: 20-12B
Nature of problem or request: I'm having back problems, feet problems
and my sinus are acting up.

Sidney Clayton
Signature

DO NOT WRITE BELOW THIS LINE

Date: ____/____/____
Time: ____ AM PM
Allergies: _____

RECEIVED
Date: _____
Time: _____
Receiving Nurse Initials _____

(S)ubjective:

(O)bjective

(A)ssessment:

(P)lan:

Refer to: MD/PA Mental Health Dental Daily Treatment Return to Clinic PRN
CIRCLE ONE

Check One: ROUTINE () EMERGENCY ()

If Emergency was PHS supervisor notified: Yes () No ()

Was MD/PA on call notified: Yes () No ()

SIGNATURE AND TITLE

WHITE: INMATES MEDICAL FILE

YELLOW: INMATE RETAINS COPY AFTER NURSE INITIALS RECEIPT



**PRISON HEALTH SERVICES, INC.
SICK CALL REQUEST**

Print Name: Sidney Clayton Date of Request: 4/10/06
 ID # 28477 Date of Birth: 3/23/76 Location: 28 12B
 Nature of problem or request: _____

I can't see to well I need my key lock.

Sidney Clayton
Signature

DO NOT WRITE BELOW THIS LINE

Date: 4/12/06
 Time: _____ AM PM
 Allergies: NKDA

RECEIVED Date: <u>4/12/06</u> Time: <u>0745</u> Receiving Nurse Initials <u>7a</u>

(S)ubjective:

(O)bjective (V/S): T: 98.2 P: 80 R: 18 BP: 132/72 WT: _____

(A)ssessment:

(P)lan:

Refer to: MD/PA Mental Health Dental Daily Treatment Return to Clinic PRN

CIRCLE ONE

Check One: ROUTINE () EMERGENCY ()

If Emergency was PHS supervisor notified: Yes () No ()

Was MD/PA on call notified: Yes () No ()

SIGNATURE AND TITLE

WHITE: INMATES MEDICAL FILE

YELLOW: INMATE RETAINS COPY AFTER NURSE INITIALS RECEIPT



60111 (5/85) **Complete Both Sides Before Using Another Sheet**



**PRISON HEALTH SERVICES, INC.
SICK CALL REQUEST**

Print Name: Sidney Clayton Date of Request: 3/28/06
 ID # 224747 Date of Birth: 3/27/76 Location: Seg 804
 Nature of problem or request: My Sinus are acting up again. This
is a recurring sickness.

Sidney Clayton
Signature

DO NOT WRITE BELOW THIS LINE

Date: 3/29/06
 Time: 3:30 AM PM
 Allergies: NKA

<p>RECEIVED Date: <u>3/29/06</u> Time: <u>9:00</u> Receiving Nurse Initials <u>DS</u></p>
--

(S)ubjective:

(O)bjective (V/S): T: P: R: BP: WT:

(A)ssessment: See Net Total.

(P)lan: Refer to MD. 3-30-06 @ 10am.

Refer to: MD/PA Mental Health Dental Daily Treatment Return to Clinic PRN
 CIRCLE ONE

Check One: ROUTINE ☒ EMERGENCY ☐

If Emergency was PHS supervisor notified: Yes ☐ No ☐

Was MD/PA on call notified: Yes ☐ No ☐

J. Adkins
 SIGNATURE AND TITLE

WHITE: INMATES MEDICAL FILE

YELLOW: INMATE RETAINS COPY AFTER NURSE INITIALS RECEIPT



Nursing Evaluation Tool:

Upper Respiratory Complaints

Facility: Ventress Correctional Facility

Patient Name: Clayton Sidney

Inmate Number: 224797

Date of Report: 3/29/06

Date of Birth: 3/23/76

Time Seen: 3:20 AM PM Circle One

Subjective: Chief Complaint(s): ☒ Runny/Stuffy Nose ☐ Sneezing ☐ Sore Throat ☐ Swollen Glands ☐ Headache ☐ Fever

(Check All That Apply)

☐ Malaise ☐ Earache ☐ Cough: ☐ No ☐ Yes ☐ Non-productive ☐ Productive: (sputum description):

☒ Other: Cold in face

Onset: 1st in 2 m

History: that going on yard for walk after meal

(Continue on back if necessary)

History of Asthma: ☐ No ☐ Yes

Cardiac/CHF history: ☐ No ☐ Yes

History of HIV Disease: ☐ No ☐ Yes

Objective: Vital Signs: (If Indicated) T: 98.8 P: 72 RR: 18 B/P: 130/90

Eyes: ☒ Clear ☐ Watery ☐ Injected (red) Drainage: ☐ No ☐ Yes

Nose: Congestion: ☒ No ☐ Yes Drainage: ☐ No ☐ Yes

Throat examination: ☐ Normal ☐ Red ☐ Enlarged tonsils ☐ Edematous

Neck: ☒ Normal ☐ Enlarged Lymph Nodes

Lung sounds: Right ☒ Clear ☐ Diminished ☐ Crackles ☐ Rhonchi ☐ Wheezing

Left ☒ Clear ☐ Diminished ☐ Crackles ☐ Rhonchi ☐ Wheezing

Assessment: (Referral Status)

☐ Referral NOT Required

☒ Referral Required

Preliminary Determination(s): Alt. My. H. Infl. Compst.

Ch. Sinus

Referral Required referral due to the following: (Check all that apply)

☐ Abnormal Vital Signs ☐ Inability to swallow ☐ Significant shortness of breath

☐ Abnormal Lung exam ☐ Significant Wheezing which does not improve with inhaler

Comment: You should contact a physician and/or a nursing supervisor if you have any concerns about the status of the patient or are unsure of the appropriate care to be given.

☐ Recurrent Complaint (More than 2 visits)

☐ Other:

Plan: Check All That Apply:

☐ Advise rest and oral fluid intake ☐ Warm saline gargles PRN

☐ If no referral is made, advise to return in 3 - 5 days if symptoms have not resolved

☒ Education: The patient demonstrates an understanding of the nature of their medical condition and instructions regarding what they should do as well as appropriate follow-up. ☐ YES ☐ NO (If NO then schedule patient for appropriate follow-up visits)

☐ Other:

(Describe)

☐ OTC Medications given ☒ NO ☐ YES (If Yes List)

Referral: ☐ NO ☒ YES (If Yes, Whom/Where) Dr. Rayapati

Referral Type ☐ Routine ☐ Urgent ☐ Emergent (if emergent who was contacted?)

Date for referral: 3/29/06

Nurses Signature: J. Odhis

Name: J. Odhis, RN

Printed



PRISON HEALTH SERVICES, INC. SICK CALL REQUEST

Print Name: Sidney Clayton Date of Request: 3/22/06
 ID # 224797 Date of Birth: 3/27/76 Location: 9A SB
 Nature of problem or request: I'm requesting to get to a non smoking facility. Mr. Brown said he has no problem with it as long as the Doctor approve it. I'm on medication and a breathing machine for my asthma

Sidney Clayton
Signature

DO NOT WRITE BELOW THIS LINE

Date: 3/22/06
 Time: 1:50 AM ☒ PM
 Allergies: NKDA

<p>RECEIVED</p> <p>Date: _____</p> <p>Time: _____</p> <p>Receiving Nurse Initials _____</p>

(S)ubjective:

(O)bjective (V/S): T: _____ P: _____ R: _____ BP: _____ WT: _____

(A)ssessment:

See Net to ab.

(P)lan:

Report to HCU Friday 3-24-06 @ 9am
for appt. c md.

Refer to: ☒ MD/PA ☐ Mental Health ☐ Dental ☐ Daily Treatment ☐ Return to Clinic PRN
 CIRCLE ONE

Check One: ROUTINE ☒ EMERGENCY ☐

If Emergency was PHS supervisor notified: Yes ☐ No ☐

Was MD/PA on call notified: Yes ☐ No ☐

J. [Signature]
SIGNATURE AND TITLE

WHITE: INMATES MEDICAL FILE

YELLOW: INMATE RETAINS COPY AFTER NURSE INITIALS RECEIPT



Nursing Evaluation Tool:

General Sick Call

Facility: Alabama Department of Corrections

Patient Name: CLAYTON

Sidney

Inmate Number: 224797Date of Birth: 3 12 31 76 ^{First} _{MM DD YYYY}Date of Report: 3 12 06 _{MM DD YYYY}Time Seen: 150 AM ☒ PM Circle OneSubjective: Chief Complaint(s): Asthma from outside bothers me.Onset: for some time.

Brief History:

(Continue on back if necessary)

Spoke to HSA concerning problem. Advised to get out S.C. Slip sheet to see Dr. And see if some thing can be done.☐ Check Here if additional notes on backObjective: Vital Signs: (As Indicated) T: 98.8 P: 73 RR: 8 B/P: 110/80

Examination Findings:

(Continue on back if necessary)

wt 197 lb sat 97% hearing muffled
can be heard on inhalation and expiration
Have been taking br. Tx for 7 days. last Tx was
5am 3/22/06. med. jay asthma noted as being
given sheet for a few cases.☐ Check Here if additional notes on back

Assessment: (Referral Status)

Preliminary Determination(s): Alt. in gas exchange☐ Referral NOT REQUIRED☐ Referral REQUIRED due to the following: (Check all that apply)☐ Recurrent Complaint (More than 2 visits for the same complaint)☒ Other: Evaluate.

Comment: You should contact a physician and/or a nursing supervisor if you have any concerns about the status of the patient or are unsure of the appropriate care to be given.

Plan: Check All That Apply:

☐ Instructions to return if condition worsens.☐ Education: The patient demonstrates an understanding of the nature of their medical condition and instructions regarding what they should do as well as appropriate follow-up. ☐ YES ☐ NO (If NO then schedule patient for appropriate follow-up visits)☐ Other: _____

(Describe):

OTC Medications given ☒ NO ☐ YES (If Yes List): _____Referral: ☐ NO ☒ YES (If Yes, Whom/Where): Dr. KayapathDate for referral: 3 12 06 _{MM DD YYYY}Referral Type: ☒ Routine ☐ Urgent ☐ Emergent (if emergent who was contacted?)

Time: _____

x

Nurses Signature

Name

Printed



PRISON HEALTH SERVICES, INC. SICK CALL REQUEST

Print Name: Sidney Clayton Date of Request: 3/14/06
 ID # 224797 Date of Birth: 3/23/76 Location: 9A5B
 Nature of problem or request: The Smoke out side is bothering me.
It is hard for me to breathe, and I'm getting dizzy.

Sidney Clayton
Signature

DO NOT WRITE BELOW THIS LINE

Date: 3/22/06
 Time: 1:50 AM ☒ PM
 Allergies: NKDA

<p>RECEIVED</p> <p>Date: <u>3/17/06</u></p> <p>Time: <u>9:00</u></p> <p>Receiving Nurse Initials: <u>DS</u></p>

(S)ubjective:

(O)bjective (V/S): T: _____ P: _____ R: _____ BP: _____ WT: _____

(A)ssessment:

see net took

(P)lan:

Report to HCU Friday 3-24-06 @ 9am.
for appt EMD.

Refer to: MD/PA Mental Health Dental Daily Treatment Return to Clinic PRN
 CIRCLE ONE

Check One: ROUTINE ☒ EMERGENCY ☐

If Emergency was PHS supervisor notified: Yes ☐ No ☐

Was MD/PA on call notified: Yes ☐ No ☐

J. Ellis, RN
 SIGNATURE AND TITLE

WHITE: INMATES MEDICAL FILE

YELLOW: INMATE RETAINS COPY AFTER NURSE INITIALS RECEIPT



Facility: VENTRESS

Patient Name: Clayton Sidney

Inmate Number: 224797

Date of Birth: 3/23/76

Date of Report: 01/03/2006

Time Seen: 0925

AM / PM Circle One

Subjective: Chief Complaint(s): back pain

Onset: When I tried to get on top rack

☐ New onset☒ Chronic condition exacerbation

Pain Scale: (1-10) 5

Type: ☐ Sharp ☐ Dull☒ Intermittent☐ ConstantNumbness: ☐ No☒ Yes

Location of Pain: lower back

Radiation of pain: ☒ No☐ Yes to:

History: didn't have any back problems until I was

(Continue on back if necessary)

in seg and I passed out and hit the toilet stool

☐ Check Here if additional notes on back

Associated symptoms: Pain on urination?

☒ No ☐ YesNausea ☒ No ☐ YesVomiting ☒ No ☐ Yes (x)

Increased urination?

☒ No ☐ Yes

Pain with cough/breathing?

☒ No ☐ Yes**Objective:** Vital Signs: (If Indicated) T: 96.5 P: 80 RR: 20 B/P: 150/100Back Exam: ☒ Tender to touch ☐ Contusion ☐ Muscle spasms ☐ Impaired range of motionAdditional Findings: ☐ Numbness ☐ Tingling ☐ Abnormal gait ☐ Weakness of extremities ☐ Foot drop ☐ Other:

Elaborate positive findings: inmate states "I just can't do any climbing"

☐ Check Here if additional notes on backLower extremities: ☒ Normal☐ Abnormal (Describe):Pedal pulses: ☒ Present☐ Absent☐ Additional Examination:

(Continue on back if necessary)

☐ Check Here if continued on back**Assessment: (Referral Status)**☒ Referral NOT Required

Preliminary Determination(s):

☐ Referral Required due to the following: (Check all that apply)☐ Loss of sensation☐ Presence of RBCs from dipstick☐ Recurrent Complaint (More than 2 visits for the same complaint)☐ Prior malignancy☐ Presence of WBCs from dipstick☐ Other:**Plan:**Check All That Apply: ☐ Work and recreation restrictions x 72 hours☐ Education on avoiding back pain ☐ Education about stretching and back exercises ☐ Instructions to return if condition worsens.☐ Education: The patient demonstrates an understanding of the nature of their medical condition and instructions regarding what they should do as well as appropriate follow-up. ☐ YES ☐ NO (If NO then schedule patient for appropriate follow-up visits)☐ Other:

(Describe)

☐ Cold Compress (Acute injury) ☐ Warm Compress☐ OTC Medications given ☐ NO ☐ YES (If Yes List):Referral: ☐ NO ☐ YES (If Yes, Whom/Where):

Date for referral: / /

MM DD YYYY

Referral Type: ☐ Routine ☐ Urgent ☐ Emergent (if emergent who was contacted?):

Time

x M. Benefield
Nurses SignatureName: Marrine Benefield

Printed



**PRISON HEALTH SERVICES, INC.
SICK CALL REQUEST**

Print Name: Sidney Clayton Date of Request: 1-3-06
 ID # 224747 Date of Birth: 3/23/76 Location: 9A 5T
 Nature of problem or request: My back is hurting. I can't get on a top rack.

Sidney Clayton
 Signature

DO NOT WRITE BELOW THIS LINE

Date: / /
 Time: AM PM
 Allergies:

<p>RECEIVED</p> <p>Date: <u>1-3-06</u></p> <p>Time: <u>9:00</u></p> <p>Receiving Nurse Initials <u>DS</u></p>

(S)ubjective:

(O)bjective (V/S): T: P: R: BP: WT:

(A)ssessment:

(P)lan: Seen per MD today 1-3-06.
Release of liability signed.

Refer to: MD/PA Mental Health Dental Daily Treatment Return to Clinic PRN

CIRCLE ONE

Check One: ROUTINE () EMERGENCY ()

If Emergency was PHS supervisor notified: Yes () No ()

Was MD/PA on call notified: Yes () No ()

Chunter, LPN
 SIGNATURE AND TITLE

WHITE: INMATES MEDICAL FILE

YELLOW: INMATE RETAINS COPY AFTER NURSE INITIALS RECEIPT



**PRISON HEALTH SERVICES, INC.
SICK CALL REQUEST**

Print Name: S. P. Gentry Date of Request: 1-3-06
 ID # 224797 Date of Birth: 3/23/76 Location: 9A ST
 Nature of problem or request: My back is hurting. I can't get on a truck.

S. P. Gentry
Signature

DO NOT WRITE BELOW THIS LINE

Date: 1/3/06
 Time: 9:00 AM PM
 Allergies: None

<p align="center">RECEIVED</p> <p>Date: <u>1-3-06</u> Time: <u>9:00</u> Receiving Nurse Initials <u>DS</u></p>

(S)ubjective:

(O)bjective (V/S): T: P: R: BP: WT:

(A)ssessment:

(P)lan:

Refer to: MD/PA Mental Health Dental Daily Treatment Return to Clinic PRN

CIRCLE ONE

Check One: ROUTINE () EMERGENCY ()

If Emergency was PHS supervisor notified: Yes () No ()

Was MD/PA on call notified: Yes () No ()

Chunter LBN
SIGNATURE AND TITLE

WHITE: INMATES MEDICAL FILE

YELLOW: INMATE RETAINS COPY AFTER NURSE INITIALS RECEIPT

PRISON
HEALTH
SERVICES
INCORPORATED

224797

RELEASE OF RESPONSIBILITY

Inmate's Name: Clayton, Sidney 224

Date of Birth: 3-23-76 Social Security No: _____

Date: 1-2-06 Time: 1930 P.M.

This is to certify that I, Clayton, Sidney, currently in
(Print Inmate's Name)
custody at the Ventress Correctional Facility, am refusing to
(Print Facility's Name)

accept the following treatment/recommendations: Keep sick call appt
(Specify in Detail)

I acknowledge that I have been fully informed of and understand the above treatment(s)/recommendation(s) and the risks involved in refusing them. I hereby release and agree to hold harmless the City/County/State, statutory authority, all correctional personnel, Prison Health Services, Inc and all medical personnel from all responsibility and any ill effects which, may result from this action/refusal and I personally assume all responsibility for my welfare.

Sidney Clayton 224797 (Signature of Inmate)**
G. Johnson LPN (Signature of Medical Person)
G. Massey (Witness)
(Witness)

**A refusal by the inmate to sign requires the signature of at least one witness in addition to that of the medical staff member.



**PRISON HEALTH SERVICES, INC.
SICK CALL REQUEST**

Print Name: Sidney Clayton Date of Request: 1-1-06
 ID # 224797 Date of Birth: 3/23/76 Location: 6B
 Nature of problem or request: My back is still bothering me. I need to
see the doctor about a bottom bunk profile.

Sidney Clayton
Signature

DO NOT WRITE BELOW THIS LINE

Date: 1/2/06
 Time: 1930 AM PM
 Allergies: None

RECEIVED	
Date:	<u>1/2/06</u>
Time:	<u>1930</u>
Receiving Nurse Initials	<u>[Signature]</u>

(S)ubjective:

(O)bjective (V/S): T: P: R: BP: WT:

(A)ssessment:

Wavier Signed

(P)lan:

Refer to: MD/PA Mental Health Dental Daily Treatment Return to Clinic PRN
 CIRCLE ONE

Check One: ROUTINE () EMERGENCY ()

If Emergency was PHS supervisor notified: Yes () No ()

Was MD/PA on call notified: Yes () No ()

G. Johnson RN

SIGNATURE AND TITLE

WHITE: INMATES MEDICAL FILE

YELLOW: INMATE RETAINS COPY AFTER NURSE INITIALS RECEIPT



Nursing Evaluation Tool:

Back Pain

Facility: VENTRESS

Patient Name: Clayton Sidney

Inmate Number: 224797

Date of Birth: 3/23/76

Date of Report: 12/18/05

Time Seen: 0830

(AM) / PM

Circle One

Subjective: Chief Complaint(s): back painOnset: 12-05-05☐ New onset☒ Chronic condition/exacerbationPain Scale: (1-10) 7Type: ☒ Sharp☐ Dull☒ Intermittent☐ ConstantNumbness: ☒ No ☐ YesLocation of Pain: back

Neck / mid-back / low back

Radiation of pain: ☐ No ☐ Yes to: _____History: C/o back pain on 12-05-05, continue

(Continue on back if necessary)

Associated symptoms: Pain on urination?

☒ No ☐ YesNausea ☒ No ☐ YesVomiting ☐ No ☐ Yes (x _____)

Increased urination?

☐ No ☐ Yes

Pain with cough/breathing?

☐ No ☐ Yes☐ Check Here if additional notes on back**Objective:** Vital Signs: (If Indicated) T: 97.8 P: 72 RR: 18 B/P: 110 / 80Back Exam: ☒ Tender to touch ☐ Contusion ☐ Muscle spasms ☐ Impaired range of motionAdditional Findings: ☐ Numbness ☐ Tingling ☐ Abnormal gait ☐ Weakness of extremities ☐ Foot drop ☐ Other: _____

Elaborate positive findings: _____

Lower extremities: ☒ Normal☐ Abnormal (Describe): _____Pedal pulses: ☒ Present☐ Absent☐ Check Here if additional notes on back☐ Additional Examination:

Continue on back if necessary

☐ Check Here if continued on back**Assessment: (Referral Status)**☐ Referral NOT RequiredPreliminary Determination(s): Consent but alt☐ Referral Required due to the following: (Check all that apply)☐ Loss of sensation☐ Presence of RBCs from dipstick☒ Recurrent Complaint (More than 2 visits for the same complaint)☐ Prior malignancy☐ Presence of WBCs from dipstick☐ Other: _____**Plan:**Check All That Apply: ☐ Work and recreation restrictions x 72 hours☒ Education on avoiding back pain ☒ Education about stretching and back exercises ☒ Instructions to return if condition worsens☐ Education: The patient demonstrates an understanding of the nature of their medical condition and instructions regarding what they should do as well as appropriate follow-up. ☐ YES ☐ NO (If NO then schedule patient for appropriate follow-up visits)☐ Other: _____

(Describe)

☐ Cold Compress (Acute injury)☐ Warm Compress☒ OTC Medications given ☐ NO ☐ YES (If Yes List): Motrin 600mg po TID x 7dReferral: ☒ NO ☐ YES (If Yes, Whom/Where): Dr. RyapateDate for referral: 12/18/05Referral Type: ☐ Routine ☐ Urgent ☐ Emergent (if emergent who was contacted?): _____

Time _____

x

Nurses Signature

Name: A Marsh RN

Printed



**PRISON HEALTH SERVICES, INC.
SICK CALL REQUEST**

Print Name: Sidney Clayton Date of Request: 12/16/05
 ID # 224797 Date of Birth: 3/23/76 Location: 6D07m seg 608
 Nature of problem or request: my back is in pain. I need something
Seg 608 for pain!

Sidney Clayton
Signature

DO NOT WRITE BELOW THIS LINE

Date: 12/18/05
 Time: _____ AM PM
 Allergies: WHD4

<p>RECEIVED</p> <p>Date: <u>12-18-05</u></p> <p>Time: <u>0800</u></p> <p>Receiving Nurse Initials <u>an</u></p>

(S)ubjective:

(O)bjective (V/S): T: 97.8 P: 72 R: 18 BP: 110/80 WT: _____

(A)ssessment:

(P)lan:

See Dr. Raggarath
12-20-05
800 an

Refer to: MD/PA Mental Health Dental Daily Treatment Return to Clinic PRN

CIRCLE ONE

Check One: ROUTINE () EMERGENCY ()

If Emergency was PHS supervisor notified: Yes () No ()

Was MD/PA on call notified: Yes () No ()

A. Manher

SIGNATURE AND TITLE

WHITE: INMATES MEDICAL FILE

YELLOW: INMATE RETAINS COPY AFTER NURSE INITIALS RECEIPT



PRISON HEALTH SERVICES, INC. SICK CALL REQUEST

Print Name: Sidney Clayton Date of Request: 12/15/05
 ID # 224797 Date of Birth: 3/23/76 Location: 6 Dorm Seg.
 Nature of problem or request: I have a bad cold. I'm also putting in a request to get my teeth cleaned by the dentist. My back is still hurting real bad.

Sidney Clayton
Signature

DO NOT WRITE BELOW THIS LINE

Date: 12/16/05
 Time: 12:00 AM (PM)
 Allergies: NKDA

<p>RECEIVED</p> <p>Date: <u>12/16/05</u></p> <p>Time: <u>9:00</u></p> <p>Receiving Nurse Initials <u>DS</u></p>

(S)ubjective:

(O)bjective (V/S): T: _____ P: _____ R: _____ BP: _____ WT: 190

(A)ssessment:

(P)lan:

Cold treatment D: d x 4 d.

Refer to: MD/PA Mental Health Dental Daily Treatment Return to Clinic PRN
 CIRCLE ONE

Check One: ROUTINE () EMERGENCY ()

If Emergency was PHS supervisor notified: Yes () No ()

Was MD/PA on call notified: Yes () No ()

J. Pedro DN.
SIGNATURE AND TITLE

WHITE: INMATES MEDICAL FILE

YELLOW: INMATE RETAINS COPY AFTER NURSE INITIALS RECEIPT



Nursing Evaluation Tool:

Upper Respiratory
Complaints

Facility: BBB	
Patient Name: Clayton	Sidney
Inmate Number: 224797	Date of Birth: 3/23/76
Date of Report: 12/16/05	Time Seen: 12:00 AM (PM) Circle One

Subjective: Chief Complaint(s): ☐ Runny/Stuffy Nose ☒ Sneezing ☒ Sore Throat ☐ Swollen Glands ☐ Headache ☐ Fever
 (Check All That Apply)
☐ Malaise ☐ Earache Cough: ☐ No ☒ Yes: ☐ Non-productive ☒ Productive: (sputum description): Yellowish
☐ Other: _____

Onset: _____

History: _____

(Continue on back if necessary)

History of Asthma: ☒ No ☐ YesCardiac/CHF history: ☒ No ☐ Yes
☐ Check Here if additional notes on back
 History of HIV Disease: ☒ No ☐ Yes

Objective: Vital Signs: (If Indicated) T: 92.8 P: 76 RR: 20 B/P: 140/90

Eyes: ☒ Clear ☐ Watery ☐ Injected (red) Drainage: ☐ No ☐ Yes: _____Nose: Congestion: ☐ No ☒ Yes Drainage: ☐ No ☐ Yes: MucusThroat examination: ☐ Normal ☐ Red ☐ Enlarged tonsils ☐ EdematousNeck: ☐ Normal ☐ Enlarged Lymph Nodes

Lung sounds:
 Right Left
☒ Clear ☐ Clear
☐ Diminished ☐ Diminished
☐ Crackles ☐ Crackles
☐ Rhonchi ☐ Rhonchi
☐ Wheezing ☐ Wheezing

☐ Additional Examination: no retinal congestion, no coughing
at this time.

Assessment: (Referral Status)

☒ Referral NOT Required☐ Referral Required referral due to the following: (Check all that apply)
☐ Abnormal Vital Signs ☐ Inability to swallow ☐ Significant shortness of breath
☐ Abnormal Lung exam ☐ Significant Wheezing which does not improve with inhaler

☐ Recurrent Complaint (More than 2 visits)
☐ Other: _____

Comment: You should contact a physician and/or a nursing supervisor if you have any concerns about the status of the patient or are unsure of the appropriate care to be given.

Plan: Check All That Apply:

☒ Advise rest and oral fluid intake ☐ Warm saline gargles PRN☒ If no referral is made, advise to return in 3 - 5 days if symptoms have not resolved
☒ Education: The patient demonstrates an understanding of the nature of their medical condition and instructions regarding what they should do as well as appropriate follow-up. ☒ YES ☐ NO (if NO then schedule patient for appropriate follow-up visits)
☐ Other: _____

(Describe)

☒ OTC Medications given ☐ NO ☒ YES (If Yes List): Cough tabs, Sudafed, CTonitReferral: ☐ NO ☐ YES (If Yes, Whom/Where): _____Date for referral: 1/1/06Referral Type: ☐ Routine ☐ Urgent ☐ Emergent (if emergent who was contacted?): _____

Time: _____

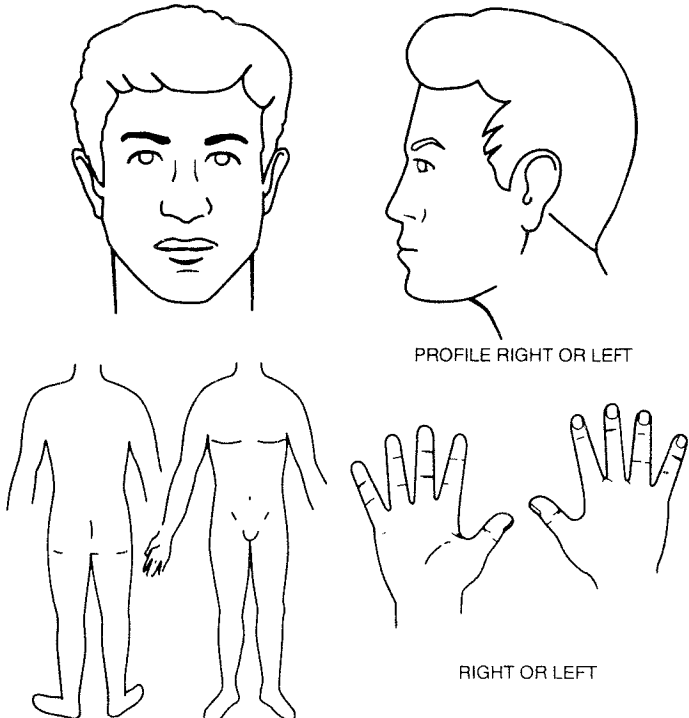

X

Nurses Signature

Name: _____

Printed

EMERGENCY

ADMISSION DATE 12/5/05		TIME 6:40 AM PM	ORIGINATING FACILITY VCF <input type="checkbox"/> SIR <input type="checkbox"/> PDL <input type="checkbox"/> ESCAPEE <input type="checkbox"/>		<input type="checkbox"/> SICK CALL <input type="checkbox"/> EMERGENCY <input type="checkbox"/> OUTPATIENT	
ALLERGIES NKDA			CONDITION ON ADMISSION <input type="checkbox"/> GOOD <input type="checkbox"/> FAIR <input type="checkbox"/> POOR <input type="checkbox"/> SHOCK <input type="checkbox"/> HEMORRHAGE <input type="checkbox"/> COMA			
VITAL SIGNS: TEMP 98 <input checked="" type="radio"/> ORAL <input type="radio"/> RECTAL		RESP 20	PULSE 87	B/P 120/84	RECHECK IF SYSTOLIC <100> 50	
NATURE OF INJURY OR ILLNESS (S) I fell and hurt my back. I feel a sharp pain in my back and I can't move.			ABRASION ///	CONTUSION #	BURN <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	FRACTURE <input type="checkbox"/> <input type="checkbox"/>
			LACERATION / SUTURES			
			 <p style="text-align: center;">PROFILE RIGHT OR LEFT</p> <p style="text-align: center;">RIGHT OR LEFT</p>			
PHYSICAL EXAMINATION (C) B/M lying beside bunk in single cell in a supine position NAD noted. Facial grimacing. Attempted assisted inmate initially along with other staff is success. Ys 8/5 stated above. Dr. Rajagani called MD given (1) Place inmate on stretcher et take to examine room et examine body. (2) Call me & report. Inmate log rolled on mattress, Mattress placed on stretcher inmate transported to examine room. No visible signs of injury noted to back. Bruising noted.			ORDERS / MEDICATIONS / IV FLUIDS Report call to MD. No given (1) Place in seg cell lying flat on back. (2) Remove all hazardous material. (3) will see in a.m.			
DIAGNOSIS			TIME BY			
INSTRUCTIONS TO PATIENT Lay flat on back.						
DISCHARGE DATE 12/5/05		TIME AM PM	RELEASE / TRANSFERRED TO <input type="checkbox"/> DOC <input type="checkbox"/> AMBULANCE <input checked="" type="checkbox"/>		CONDITION ON DISCHARGE <input checked="" type="checkbox"/> SATISFACTORY <input type="checkbox"/> POOR <input type="checkbox"/> FAIR <input type="checkbox"/> CRITICAL	
NURSE'S SIGNATURE G. Massy		DATE 12/5/05	PHYSICIAN'S SIGNATURE 		CONSULTATION	
INMATE NAME (LAST, FIRST, MIDDLE) Crafton Sidney			DOC# 224797	DOB 3/23/76	R/S B/M	FAC VCF



PRISON HEALTH SERVICES, INC. SICK CALL REQUEST

Print Name: Sydney Clayton Date of Request: 12/7/05
 ID # 224797 Date of Birth: 3/23/76 Location: Health Care
 Nature of problem or request: I need bottom bunk profile, I need to renew
Showering profile, I need to see about double portions of food
I have lost a lot of weight

Sydney Clayton
Signature

DO NOT WRITE BELOW THIS LINE

Date: 12/8/05
 Time: 12:25 AM PM
 Allergies: NRDA

<p>RECEIVED Date: <u>12/8/05</u> Time: <u>8:30</u> Receiving Nurse Initials <u>DS</u></p>
--

(S)ubjective:

(O)bjective (V/S): T: _____ P: _____ R: _____ BP: _____ WT: 190

(A)ssessment:

(P)lan:

Refer to: MD/PA Mental Health Dental Daily Treatment Return to Clinic PRN
 CIRCLE ONE

Check One: ROUTINE () EMERGENCY ()

If Emergency was PHS supervisor notified: Yes () No ()

Was MD/PA on call notified: Yes () No ()

[Signature]

SIGNATURE AND TITLE

WHITE: INMATES MEDICAL FILE

YELLOW: INMATE RETAINS COPY AFTER NURSE INITIALS RECEIPT

Facility: YENTRESS	
Patient Name: <u>Clayton</u>	<u>Sidney</u>
Inmate Number: <u>224 797</u>	Date of Birth: <u>3</u> / <u>12</u> / <u>31</u> ^{MM} ^{DD} ^{YY}
Date of Report: <u>12</u> / <u>8</u> / <u>05</u> ^{MM} ^{DD} ^{YY}	Time Seen: <u>12:25</u> AM / PM <input checked="" type="radio"/> Circle One

Subjective: Chief Complaint(s): Bottom Burn, Nausea, Double
Food Poison
Onset: _____

Brief History: small bit double portion food. Nausea
(Continue on back if necessary) Pringles B.B. will be addressed when I'm in
discharged from hosp. Aug.

☐ Check Here if additional notes on back

Objective: Vital Signs: (As Indicated) T: 97.6 P: 80 RR: 20 B/P: 140/84

Examination Findings: will give kenacort & Pringles. Double
(Continue on back if necessary) portion and B.B. will be addressed by Dr. W.
no double portion needed w/ & w/ within
normal limits.

Assessment: (Referral Status)

Preliminary Determination(s): Comfort Attended

☐ Check Here if additional notes on back

☒ Referral NOT REQUIRED

☐ Referral REQUIRED due to the following: (Check all that apply)

☐ Recurrent Complaint (More than 2 visits for the same complaint)

☐ Other: _____

Comment: You should contact a physician and/or a nursing supervisor if you have any concerns about the status of the patient or are unsure of the appropriate care to be given.

Plan: Check All That Apply:

☐ Instructions to return if condition worsens.

☐ Education: The patient demonstrates an understanding of the nature of their medical condition and instructions regarding what they should do as well as appropriate follow-up. ☒ YES ☐ NO (If NO then schedule patient for appropriate follow-up visits)

☐ Other: Removal
(Describe)

OTC Medications given ☒ NO ☐ YES (If Yes List): _____

Referral: ☒ NO ☐ YES (If Yes, Whom/Where): _____

Date for referral: ____ / ____ / ____
^{MM} ^{DD} ^{YY}
Time: _____

Referral Type: ☐ Routine ☐ Urgent ☐ Emergent (if emergent who was contacted?): _____

x J. C. Davis
Nurses Signature

Name: J. C. Davis RN
Printed



INFIRMARY NURSING PROGRESS NOTES

Date/Time	
12-7-05 7:05	7:00am - Seen about the same 11 - 11/5 wt 188, P63 P20, P2 Sat 96% Bp 119/70 T 96.8, Ambulates c steady gait no % pain @ this time, consumed 100% hammed D/E to see MD this am. Allen
12-7-05 9:35	P/E - Seen by Dr. Pygati D/d to DOC/Seg, D/d from medical, J. Martin
3-7-06	P. Annual physical done - TB shot given. Mcnequid f



Nursing Evaluation Tool:

Abdominal Pain

Facility: VENTRESS

Patient Name: Clayton Sidney

Inmate Number: 224797

Date of Birth: 3/23/76

Date of Report: 12/14/05

Time Seen: 243

AM

PM

Circle One

Subjective: Chief Complaint: "I'm Dizzy" I ate all my food
Onset: I've been throwing up all day since breakfast
History: (12-3-05) Vomited last @ 12:00 AM tonight
(Continue on back if necessary) liquid & undigested food.

Pain Description: ☐ Sharp ☐ Dull ☒ Crampy ☐ Burning
☒ Intermittent ☐ Constant ☐ Radiation to: _____
☐ Other: _____

Location: ☐ RUQ ☐ LUQ
☐ RLQ ☐ LLQ
☐ Epigastric ☐ Diffuse

☐ Check Here if additional notes on back

Last BM: _____ ☒ Normal ☐ Constipation ☐ Diarrhea x _____ stools Color change: ☒ No ☐ Yes: _____
Associated symptoms: Nausea ☐ No ☒ Yes Vomiting ☐ No ☒ Yes (x 3) Painful urination ☐ No ☐ Yes
Back pain ☒ No ☐ Yes Other: _____

* **FEMALE: LMP:** ____/____/____ **Vaginal Discharge:** ☐ No ☐ Yes (Describe): _____
MM DD YYYY

Pregnancy Test: negative / positive / NA (Circle One) * The possibility of pregnancy exists for any female of potential childbearing age unless a bilateral oophorectomy or hysterectomy has been performed

Objective: Vital Signs: (If Indicated) T: 98.° P: 66 RR: 18 B/P: 120/77

General appearance: ☒ No acute distress ☐ Acute distress ☐ Unable to stand erect ☐ Knees drawn up
Skin: ☒ Warm ☐ Cool ☒ Dry ☐ Moist/clammy **Skin Color:** ☒ Normal ☐ Pallor ☐ Flushed ☐ Jaundice
Mucous Membranes: ☒ Moist ☐ Dry

ABDOMINAL EXAM

Bowel sounds: ☒ Present ☐ Decreased ☐ Absent

Abdomen: ☒ Soft ☒ Guarding ☐ Distended ☐ Non-Tender ☒ Tender all 4 quadrants
Location

Pain induced/increased with: Walking ☒ No ☐ Yes

Pain induced/increased with: Gentle abdominal palpation ☐ No ☒ Yes

☐ Additional Examination: I make clo pain in abd everywhere
(Continue on back if necessary) palpated. No vomiting by myself or officers. noted
☐ Check Here if continued on back

Assessment: (Referral Status)

☒ **Referral Not Required**

Preliminary Determination(s): _____

☐ **Referral Required** due to the following: (Check all that apply)

- ☐ Abnormal Vital Signs ☐ Distended/rigid abdomen ☐ Persistent Nausea and/or vomiting
☐ Bloody or "Tarry" stools ☐ Pallor, moist clammy skin ☐ Recurrent Complaint (More than 2 visits for the same complaint)
☐ Other: _____

You should contact a physician or nursing supervisor if you have any questions about the status of the patient.

Plan:

Check All That Apply:

- ☒ Instructions to return if condition worsens or does not improve inform officer
☐ Education on bowel elimination ☐ Education on Lifestyle Modifications to prevent reflux
☒ Education The patient demonstrates an understanding of the nature of their medical condition and signs and symptoms for which they should seek additional medical attention. (Persistent vomiting, significant weakness, signs of dehydration, worsening abdominal pain, fever) as well as appropriate follow-up. ☐ YES ☐ NO (If NO then schedule patient for appropriate follow-up visits)
☐ OTC Meds given ☒ Pepto-Bismol 10-15 cc PO X1 dose (or) ☐ Maalox 30 cc PO X1 dose
☐ Other OTC Medications given ☐ NO ☐ YES (If Yes List): _____

Referral: ☒ NO ☐ YES (If Yes, Whom/Where): _____ **Date for referral:** ____/____/____
MM DD YYYY

Referral Type: ☒ Routine ☐ Urgent ☐ Emergent (if emergent who was contacted?) _____ **Time** _____

x

Nurses Signature

Printed



PRISON
HEALTH
SERVICES
INCORPORATED

INFIRMARY NURSING PROGRESS NOTES

Date/Time	
12-6-05 2400	<p>S "gl m steel in pain"</p> <p>O Lying on back on floor in supine. resp. reg & unlabored abd soft B5+. Males exts on commind pedal pulse to & exts. B/P 110/70 18 98.4 80 SKIN w/d aro x3. No acute distress</p> <p>A. Att in comfort. R.H. pain.</p> <p>P. Cont to observe.</p> <p>E. inst to call nurse for any problems or c/o.</p>
12-6-05 0330	<p>O Tol 100% diet when ate breakfast in a sitting position. No nausea or vomiting noted.</p>
12-6-05 0500	<p>Resting & distress resp. reg & unlabored</p> <p>No distress noted.</p>
0800	<p>O Lying on floor on mat on R. Side.</p> <p>Reacts to verbal.</p>
11 ¹⁵	<p>O Wt. 186, BP 112/60, P 60 T 98.0 R 20, O2 98, SpO2 98</p> <p>O Seen by Dr. Rayapati - O2 sat noted 98</p> <p>O Sitting up on mattress propped against wall</p> <p>NO acute distress noted.</p> <p>A) Att. Comfort R.T. Pains & Discomfort.</p> <p>P) Monitor / provide meds.</p>

INMATE NAME (LAST, FIRST, MIDDLE)

DOC#

DOB

R/S

FAC.

Crayton, Sidney

224797

2-23-74

B/M

VCF